CHRISTIAN PSYCHOTHERAPY SERVICES

Authorization to Release/Receive/Exchange (circle one) Confidential Information

Please print legibly and accurately or this may cause a delay in processing.

(1) Name: ______________________ Date of Birth: ______________

Address: ______________________ Current Phone Number:(____)__________

City: ______________________ State: __________ Zip Code: __________

In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request

I hereby authorize ____

(Specific Name of Therapist or Medical Provider at CPS) to release or exchange:

____

(Patient's Name) medical records including HIV/AIDS, Psychiatric/ drug abuse and alcohol related information, if applicable to/from with: ______________________ City__________ State__________ Zip____

(Address of the person/agency is to be released)

Phone#: ______________________ / Fax #: ______________________

(Fax and/ or phone number of the person/agency information that is to receive the information.)

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of *super-confidential information* as stated in the NOPP (initial where appropriate):

(2) Specific information that is to be released:

___ Psychiatric/ Initial Diagnostic Interview ___ Clinic Visits/Psychotherapy Ns __ History/ Physical __ Order

___ Psychological Test Results ___ Labs and diagnostic test results ___ Hospital/ Admission/Discharge Summary

___ School records___ Medication Records___Grant permission to make appointments for patient (write below)

____

(3)The purpose of the exchange of information:

___ Continuity of Care ___ Referral to another provider ____ Court Related Issues __ Discharge Plans

(4) I understand that I may revoke this authorization at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not constitute a breach of my right of confidentiality. Unless I revoke the authorization shall expire on _______ (Specific Date), or ____ (90 days) ____(365 Days)

Pick up method ____________ Fax ___Mail ___ Pick up at office location (check the box below for which office)

Client Signature: ______________________ Date: ______________

Patient/Legal Guardian: ______________________ Date: ______________

Witness Signature: ______________________ Date: ______________

☐Virginia Beach Office: 4460 Corporation Lane Suite #100, 23462 (757) 490-0377; Fax number (757) 497-1327

☐Chesapeake Office: 609 Independence Parkway #115 23320 (757) 312-8002; Fax Number (757) 312-9299

☐Suffolk Office: 3897 Bridge Rd, #104 23435 757-394-1961; Fax Number (757) 394-1965

☐Newport News Office: 11838 Rock Landing II, #145 (757) 873-0735; Fax Number (757) 873-0148

☐Norfolk Office: 142 West York Street Suite 805 23510 (757) 622-2114; Fax Number (757) 622-2449